Example—In a case involving arthritis of the shoulder, where the X–rays confirm bone destruction, the examinations indicate minimal swelling and inflammation, but the treating source supplies evidence of greater restriction in the range of motion than found by the consultative physician, the Board will ask the treating source for further interpretation of the range of motion studies. If the treating source supplies a reasonable explanation. e.g., that the individual's condition is subject to periods of aggravation, the treating source's explanation will be given some extra weight over that of the consultative physician.

(e) *Medical opinions that will not be considered conclusive nor given extra weight.* The Board will not consider as conclusive nor give extra weight to medical opinions which are not in accord with the statutory or regulatory standards for establishing disability. Thus, opinions that the individual's impairments meet the Listing of Impairments in appendix 1 of this part, where the medical findings which are the basis for that conclusion would not meet the specific criteria applicable to the particular impairment as set out in the Listing will not be conclusive nor given extra weight. Likewise, an opinion(s) as to the individual's residual functional capacity which is not in accord with regulatory requirements set forth in §§ 220.120 and 220.121 will not be conclusive nor given extra weight.

Example 1—A medical opinion that an impairment meets listing 2.02 but the medical findings show that the individual's visual acuity in the better eye after best correction is 20/100, would not be conclusive nor would it be given extra weight since listing 2.02 requires that the remaining vision in the better eye after best correction be 20/200 or less.

Example 2—A medical opinion that the individual is limited to light work when the evidence shows that he or she can lift a maximum of 50 pounds and lift 25 pounds frequently will not be considered as conclusive nor given extra weight. This is because the individual's exertional capacity exceeds the criteria set forth in the regulations for light work.

§ 220.113 Symptoms, signs, and laboratory findings.

Medical findings consist of symptoms, signs, and laboratory findings:

(a) *Symptoms* are the claimant's own description of his or her physical or mental impairment(s). The claimant's statements alone are not enough to establish that there is a physical or mental impairment(s).

(b) *Signs* are anatomical, physiological, or psychological abnormalities which can be observed, apart from the claimant's own statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation and contact with reality. They must also be shown by observable facts that can be medically described and evaluated.

(c) *Laboratory findings* are anatomical, physiological, or psychological phenomena which can be shown by the use of medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.) x–rays, and psychological tests.

§ 220.114 Evaluation of symptoms, including pain.

The Board considers all of the claimant's symptoms, including pain, and the extent to which signs and laboratory findings confirm these symptoms. The Board will not find the claimant disabled based on his or her symptoms unless medical signs or findings show a medical impairment that could be reasonably expected to produce those symptoms.

§ 220.115 Need to follow prescribed treatment.

(a) *What treatment the claimant must follow.* In order to get a disability annuity, the claimant must follow treatment prescribed by his or her physician if this treatment can restore the claimant's ability to work.

(b) *When the claimant does not follow prescribed treatment.* If the claimant does not follow the prescribed treatment without a good reason, the Board will find him or her not disabled or, if the claimant is already receiving a disability annuity, the Board will stop paying the annuity.

(c) *Acceptable reasons for failure to follow prescribed treatment.* The following

are examples of a good reason for not following treatment:

(1) The specific medical treatment is contrary to the established teaching and tenets of the claimant's religion.

(2) The prescribed treatment would be cataract surgery for one eye, when there is an impairment of the other eye resulting in a severe loss of vision and is not subject to improvement through surgery.

(3) Surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.

(4) The treatment because of its magnitude (e.g., open heart surgery), unusual nature (e.g., organ transplant), or other reason is very risky for the claimant.

(5) The treatment involves amputation of an extremity, or a major part of an extremity.

Subpart J—Residual Functional Capacity

§ 220.120 Residual functional capacity, defined.

(a) *General.* (1) The claimant's impairment(s) may cause physical and mental limitations that affect what the claimant can do in a work setting. Residual functional capacity is what the claimant can do despite his or her limitations. If the claimant has more than one impairment, the Board will consider all of his or her impairments of which the Board is aware. The Board considers the claimant's capacity for various functions as described in the following paragraphs: (b) physical abilities, (c) mental impairments, and (d) other impairments. Residual functional capacity is a medical assessment. However, it may include descriptions (even the claimant's) of the limitations that go beyond the symptoms that are important in diagnosis and treatment of the claimant's medical impairment(s) and may include observations of the claimant's work limitations in addition to those usually made during formal medical examinations.

(2) The descriptions and observations of the limitations, when used, must be considered along with the rest of the claimant's medical records to enable the Board to decide to what extent the claimant's impairment(s) keeps him or her from performing particular work activities.

(3) The assessment of the claimant's residual functional capacity for work is not a decision on whether the claimant is disabled, but is used as the basis for determining the particular types of work the claimant may be able to do despite his or her impairment(s). A claimant's vocational background (see §§ 220.125 through 220.134) is considered along with his or her residual functional capacity in arriving at a disability decision.

(b) *Physical abilities.* When the Board assesses the claimant's physical abilities, the Board assesses the severity of his or her impairment(s) and determines his or her residual functional capacity for work activity on a regular and continuing basis. The Board considers the claimant's ability to do physical activities such as walking, standing, lifting, carrying, pushing, pulling, reaching, handling, and the evaluation of other physical functions. A limited ability to do these things may reduce the claimant's ability to do work.

(c) *Mental impairments.* When the board assesses a claimant's mental impairment(s), the Board considers the factors, such as—

(1) His or her ability to understand, to carry out, and remember instructions; and

(2) His or her ability to respond appropriately to supervision, co-workers, and work pressures in a work setting.

(d) *Other impairments.* Some medically determinable impairments, such as skin impairments, epilepsy, and impairments of vision, hearing, or other senses, postural and manipulative limitations, and environmental restrictions do not limit physical exertion. If the claimant has this type of impairment, in addition to one that affects physical exertion, the Board considers both in deciding his or her residual functional capacity.

§ 220.121 Responsibility for assessing and determining residual functional capacity.

(a) For cases at the initial or reconsideration level, the responsibility for